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St. Bartholomew's Hospital Journal,

NOVEMBER 14th, 1897.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

Contributions towards a History of the Surgical Teaching at St. Bartholomew's Hospital during the Nineteenth Century.

By D'ARCY POWER, F.R.C.S., F.S.A., Demonstrator of Practical and Operative Surgery.

IV. THE METHODS OF TEACHING.

THERE have been remarkable variations in the methods of teaching adopted during the present century. Not only has the manner of instruction varied with each individual, as must always be the case, but the very system itself has altered greatly from time to time. The original method of teaching surgery was purely clinical. The pupil followed his master to the bedside and watched the measures he adopted in curing his patient, asking such questions as might occur to him on the spur of the moment. There are traces of such a method in the interesting "Anatomical and Practical Observations in St. Thomas his Hospital, made by J. Molins, 1674 to 1677," the friend of Wiseman, which were lately published by Dr. Payne in the *St. Thomas's Hospital Reports,* and no doubt a similar plan was followed in our own Hospital.

The principles and the theory of surgery were taught at this time by a series of public lectures delivered at the College of Physicians and at the Barber-Surgeons' Hall in Monkwell Street. Percivall Pott with us, and Samuel Sharpe at Guy's Hospital, first gave individual lectures on surgery to small classes,—Pott privately to his own pupils who were students at the Hospital, Sharpe to a class of navy surgeons who were anxious to improve themselves. Both courses became very celebrated. Pott's lectures were attended by most of the celebrated surgeons in Europe, and were gratefully recognised by the Governors of St. Bartholomew's Hospital, who built him a theatre to accommodate his audience. Sharpe's lectures were continued by William Hunter, and thus became the origin of the Hunterian or Great Windmill Street School of Medicine, the foundation of modern medical teaching.

The success of the Hunterian School was due to the fact that its pupils were thoroughly grounded in anatomy, and that they were taught systematically the great principles underlying the practice of their profession. The backbone of the school was its anatomy, for the students dissected from early morn till late at night, their work being superintended by such men as John Hunter, Hewson, Sheldon, Cruikshank, Wilson, and Matthew Baillie, who acted successively as demonstrators to William Hunter. The importance of this training will be understood when it is remembered that until William Hunter opened his school (after the formation of the Surgeons' Company in 1745) the dissection of a dead body, except at the College of Physicians or at the Barbers' Hall, led to the fine or even to the im-

prisonment of the enterprising anatomist. Not more than five or six men in London, therefore, had ever had a scalpel in their hands, and the average knowledge of anatomy was only such as could be gained by seeing a dead body cut up in from three to five days.

Botany was soon added to anatomy as an important item in the curriculum of the medical student, for, like anatomy, it bore some affinity to an exact science. The reawakening of the Apothecaries' Society after the passing of the Apothecaries Act in 1815 was marked by a very thorough teaching of botany to every medical student who took his L.S.A.

Thomas Wheeler (1754—1847), Apothecary to the Hospital, was also Custos of the Society's gardens at Chelsea, and Demonstrator of Botany. His herborising expeditions soon became a remarkable feature in the life of the London medical student. Many good stories are told of Mr. Wheeler, a most simple, unassuming man, who lived to be ninety-four. The following is perhaps one with the strongest local flavour. He was very peculiar in his style of dress, carrying simplicity in this respect almost to the verge of eccentricity. It is said that he was one evening sitting at the back of the "shop," as the dispensary is still called in the Hospital, with a number of students who were bantering him and each other, and he was descanting on the folly of superfluity in dress, when Lawrence said, with his usual assumed air of gravity, "Well, Mr. Wheeler, how can you support such a doctrine while you wear such a superfluity as this?" lifting up a small queue or pigtail which Wheeler wore. Thus taken aback, the old man confessed that it was superfluous. "Yes, my dear sir, you are right; we are too prone to preach one thing and to practise another. I never thought of it: cut it off, sir, pray cut it off;" and Lawrence forthwith performed the amputation requested.

The plan of instruction in botany was for the demonstrator to discourse in the open air at certain fixed periods during the summer months to the members of the Society and their apprentices. The medical plants were arranged in systematic order in a certain part of the garden, and the demonstrator showed them to his pupils, explaining as he went from bed to bed their botanical characters, their place in the Linnæan classification, and their uses in medicine.

As early as 1633, however, the Society of Apothecaries organised a system of herborisings, which continued for the long period of two hundred years. Originally there was but one gathering in the year, but the number was gradually increased to six, of which five were attended by the apprentices of the Apothecaries' Society under the superintendence of the demonstrator, and one of them, called the General Herborising, was confined to the members only. The custom was for the apprentices to assemble punctually at six o'clock in the morning at St. Bartholomew's Hospital, while Mr. Wheeler held the post of Apothecary at that institution (1806—1820). An official of the Apothecaries' Society carried a large metal box for the collection of the specimens, and each student carried a similar though smaller box, slung round his shoulder for the same purpose. None carried umbrellas or great-coats, and if the rain came down the clothes were allowed to dry when the sun shone again.

Different routes were pursued on different occasions. Sometimes the excursion was to the north-west, passing through Islington, where it was still possible to find the deadly nightshade (*Atropa belladonna*) growing wild in a ditch in Goswell Road; then through Copenhagen Fields and Kentish Town, to Hampstead Heath, where a halt was called at "Jack Straw's Castle." There the company breakfasted on tea, rolls, and butter, after which they scattered themselves about the heath, gathering ferns and heath plants. The ramble was conducted to Finchley, Hendon, or Caen Wood, the party returning to the inn for dinner, which consisted of substantial joints of meat and pudding, with a moderate allowance of table ale. "Formerly," says Dr. Semple, from whose edition of 'Field's Memoirs' of the Botanic Garden at Chelsea this account is taken, "the apprentices were once a year at least indulged in wine," for at a committee held at Chelsea Garden in the year 1823 it was ordered that "the pupils at private herborisings should be allowed a bottle of wine among four, and a bottle of cider between two, but that no porter or other malt liquor should be allowed except table beer." Immediately after dinner the large metal box carried by the attendant was opened, and the plants collected during the excursion were produced and exhibited to the students, who were seated on each side of a long table. The name of each plant was given, together with the peculiarities of form or structure by which it was distinguished; and if it possessed any medicinal qualities, it would receive special attention as to its therapeutical uses. The students were then free to go home as they liked. Another route lay along the Old Kent Road to Blackheath, where breakfast was taken at the "Green Man," and another from Blackfriars into Battersea Fields, the present Battersea Park. Breakfast in this case was ordered at the "Star and Garter," Putney.

The success of the Hunterian School, and the increasing requirements of the College of Surgeons and the Society of Apothecaries, led to the establishment of a series of private schools in London. Some of these, like the Aldersgate Street School, of which mention has been made in a previous article, gave a complete course of instruction, others taught single subjects, but all agreed in giving a most thorough grounding in anatomy. Of some of the methods adopted in these schools we have already spoken, but the plans of imparting knowledge adopted by the private teachers were sometimes very curious. Thus J. C. Carpue, who was known as "the chalk lecturer," from the facility with which he extemporised blackboard diagrams when subjects were scarce, made his pupils learn their bones by rote. He first

described the different parts of a bone, and he then called upon a student by name to demonstrate the bone to others in the same words as he had used. This done, it was given to a third student, and so on until the process had been repeated fourteen or fifteen times in succession. It is recorded that he had a temporal bone with its styloid process broken off, and that after repeating the other parts he would say, "the styloid process broken off." One of his pupils, on presenting himself at the College of Surgeons, was asked to describe the temporal bone; which he did after the manner of Carpue, much to the amusement of the Court of Examiners. "The styloid process broken off!" said old Sir William Blizard in astonishment, for it was about two inches long. And when the student explained, the veteran surgeon laughed heartily at the joke. Dermott, another of the great private teachers in anatomy and surgery, taught in a different manner. He was very unpunctual in the time of beginning his lectures. His afternoon discourse usually occupied two hours, and if he observed symptoms of weariness in his audience he would say, "Gentlemen, you are fatigued with your labours; let us have a little interlude to revive you." He would leave off his teaching for a few minutes, and deliver himself of the soliloquy of Hamlet, or the death scene in Richard III, amidst the enthusiastic applause of his audience.

In our school teaching at the present time there are remnants, as if atavistic, of both methods of teaching, unvaried, alas! by the histrionic talents of a Dermott. There are the dull and formal demonstrations of the dark winter afternoons, in which the demonstrator of surgery does all the talking; and there are the much more useful tutorial classes conducted on strictly Socratic lines.

The private teachers were practically starved to death by an ordinance of the Royal College of Surgeons, which enacted that the teaching of anatomy should be carried out during the winter session, and that summer classes would not be recognised after 1824. The private schools which gave more than a course of anatomy and surgery lingered for some time longer, almost the last being the Grosvenor Place School, which was very ably conducted by Samuel Lane.

The passing of the Medical Act in 1858 gave a great impetus to all systematic teaching. At first lectures counted for everything, but little by little it yielded to the present method of many demonstrations and comparatively few lectures. In our own school this system was inaugurated by the appointment of Mr. Willett as the first Demonstrator of Surgery in the summer of 1871. Before this time every student had to attend two courses of Lectures on Surgery, but in this year the Royal College of Surgeons of England required that candidates for the final examination should attend one course of lectures and one course of demonstrations. Mr. Willett secured the office of Demonstrator of Surgery for five years, and his place was taken in due course by Mr. Marsh; Mr. Butlin and Mr. Walsham replaced Mr. Marsh, and were in turn succeeded by Mr. Bowlby and myself.

The destruction of the private schools, coupled with the advent of a stricter system of examinations, gave rise to a new genus of teacher—the "grinder." He is now as extinct as the dodo, but his methods are crystallised in Albert Smith's skit, "The Physiology of the London Medical Student." Of these unfortunate people he says, "Not only is the medical grinder intimately acquainted with the different branches required to be studied, but he is also master of all their minutiæ.

"In accordance with the taste of the examiners, he learns and imparts to his class at what degree of heat water boils in a balloon; how the article of commerce, *Prussian blue*, is more easily and correctly defined as *ferrosesquicyanuret of the cyanide of potassium;* why nitrous oxide, or laughing gas, induces people to make such asses of themselves; what you would do if you were called to see a tipsy barber who had cut his throat with a razor, or divided his carotid artery with his scissors, and especially all sorts of individual inquiries." As an instance of his methods Albert Smith gives the following dialogue:

"Now, Mr. Muff," says the gentleman, handing him a bottle of something which appears like specimens of a chestnut colt's coat after he has been clipped, "what's that, sir?" "That's cowitch, sir," replies Mr. Muff. "Cow what? that won't do, sir. You must call it at the Hall by its botanical name, *Dolichos pruriens*. What is it used for?" "To strew in people's beds that you owe a grudge to," replies Mr. Muff, whereat all the class laugh except the last comer, who takes it all for granted, and makes a note of the circumstance in his interleaved manual; but it is right to say that after attending the grinding class two or three times he runs his pencil through this note as valueless. "That answer would floor you," continues the grinder. "The Dolichos is used to destroy worms.—How does it act, Mr. Jones?" going on to the next pupil. "It tickles them to death, sir," answers Mr. Jones. "You would say it acts mechanically," observes the grinder. "The fine points stick into the worms and kill them. They say, 'Is this a dagger which I see before me?' and then die. Recollect the dagger, Mr. Jones, when you go up. I have known three men saved of an evening by remembering the dagger, Mr. Jones."

The professional grinders of this type spent their lives at the work, and aspired to nothing higher. We, though more timely happy, find that eight or ten years of similar drudgery too often crushes out of us all originality, and leaves us without the inclination or the ability to further the scientific progress of our profession.

THE Title-page and Index to Volume IV are unavoidably held over till next month.

Diseases often Overlooked.

A paper read before the Abernethian Society on October 28th, 1897.

By J. D. RAWLINGS, M.B.(Lond.).

MY object this evening is not to discuss elaborate methods of diagnosis or to raise questions of deep theoretical interest, but rather to point out a few conditions which are in most cases easy to diagnose, but are often overlooked merely because they are not looked for or thought of, and which thus form a series of pitfalls for any man, however well read, until he has either suffered by them himself or witnessed the discomfiture of a *confrère*.

Of all chronic diseases that which is most commonly overlooked is *chronic interstitial nephritis*. From the clinical point of view this is practically the same disease as arterio-sclerosis or arterio-capillary fibrosis; the only difference between them is that in granular kidney the change occurs first in the kidneys and affects secondarily the cardio-vascular system, whereas in arterio-sclerosis the primary change is in the cardio-vascular system and spreads to the kidneys. The two diseases present the same clinical picture, and often cannot be distinguished with the naked eye after death. Granular kidney is a far more common disease than most people think; it is not so exclusively confined to middle and old age as the text-books lead us to suppose; its onset is insidious in the extreme; it may progress for many years without causing any symptoms at all, and the symptoms when they do occur are often very indefinite, and not in any way calculated to direct one's attention to the kidneys. Œdema, for instance, does not usually occur, and the albumen and casts may either be absent from the urine altogether or may occur in such small quantities as to be easily missed. Consequently, anyone who is not constantly on the look-out for this disease is sure to overlook a large proportion of the cases that come to him. On the other hand, no disease is easier to recognise when looked for; the hypertrophied left ventricle, the hard tortuous arteries, the low specific gravity of urine may be recognised with certainty by any man who has done his auscultation and percussion classes. The *albumen* often has to be looked for very carefully; by far the best way to find a minute trace of albumen is to boil the top inch or so of the urine in a test-tube, add a drop of acetic acid, see that the outside of the tube is quite clean, and then hold it up to the light with a dark background formed by a black coat sleeve. In this way minute traces of albumen may be recognised which I defy anybody to be certain of by the nitric acid test. The specimen chosen should be one passed after food or after exercise; I have often found that the urine passed by a patient immediately after admission to the hospital has contained a minute trace of albumen which has been absent from all subsequent specimens while he is in the ward. I had the good fortune to be Dr. West's house physician at the Royal Free before I came on at this Hospital, and to Dr. West I am indebted for impressing these facts upon me. As a result of his teaching I looked for the signs of granular kidney in every middle-aged or elderly man who came to the surgery with indefinite but persistent symptoms *of any kind*, and I was astonished at the number of such cases in which they were present. The following are some of the symptoms which have brought my granular kidney patients to the hospital.

Indigestion, general debility and lassitude with inability to work, headache, occasional attacks of giddiness, symptoms of anæmia, rheumatic pains in the shoulders or back, muscular cramps, neuralgia of the face and elsewhere, spitting up blood, eczema, palpitation, cough and shortness of breath, epistaxis, loss of sight. Deafness and tinnitus are said to occur.

I can only recall one case in which the increased quantity of urine brought the patient to the hospital, and in that case, curiously enough, the patient was referred by the casualty officer not to the physician but to the gynæcologist. She was a woman of sixty who gave the history that three months ago she had had some marital troubles, and that she had since been troubled with frequent micturition. No local cause was found by the gynæcologist, and she was accordingly sent to the medical out-patient department, and was there found to have well-marked cardio-vascular signs of granular kidney. And, moreover, the symptom she complained of was not merely frequent micturition but true polyuria.

General debility and laziness are perhaps the commonest symptoms of the disease; they almost always occur whether there are other symptoms or not. A tradesman once brought one of his employés to the hospital complaining that he had been doing his work so badly for some time past that he had been obliged to discharge him; and the man had excused himself on the ground of health. The man was in a pitiable condition, for he knew that he was working badly and felt that ruin was staring him in the face, but could not pull himself together. These people, by the way, always take the most gloomy possible view of their prospects. This man had granular kidney with emphysema and an unusually large quantity of albumen in the urine—about a quarter.

Headache and giddiness are very constant symptoms. The headache may be secondary to dyspepsia, or it may be uræmic, or due to high blood-pressure in the cerebral circulation, or to atheroma of the cerebral arteries cutting off the blood-supply from parts of the brain. The vertigo is partly due to atheromatous vessels, partly to increased blood-pressure in the brain; it also occurs in syphilitic endarteritis. When a middle-aged sallow-faced man complains of persistent headache with occasional attacks of giddiness, by far the most probable cause is granular kidney. I should say that in middle-aged people granular kidney is a *more* frequent cause of *dyspepsia* than phthisis is in young people. The vomiting of granular kidney may be either gastric or central, and this disease is one of the causes of *morning sickness*, simply because a person with atheromatous cerebral arteries is liable to vertigo on any sudden change of position, and suffers, therefore, on rising in the morning. The same applies also to cases of cerebral tumour. In a small percentage of cases *loss of sight* is the first thing complained of. I have seen one or two such cases, and Dr. West has published some. Osler says, "It is remarkable in how many cases of interstitial nephritis the condition is diagnosed first by the ophthalmic surgeon." A woman of about fifty-five came to Moorfields in the early part of this year complaining of loss of sight; she had not been treated elsewhere for any other symptoms. On examination with the ophthalmoscope she was found to have very extensive albuminuric retinitis; the cardio-vascular and urinary signs of granular kidney were then looked for and found. It must be borne in mind that albuminuric retinitis generally is very extensive before the patient complains of failing sight.

In one of Dr. West's cases the first thing noticed by the patient was that he could not see a wire fence when hunting. A fortnight later he had lost all vision except the perception of light. Dr. West then saw him, and found extreme albuminuric retinitis; a week later he died with pericarditis, *i.e.* three weeks from the time the first symptom was noticed.

The *most striking* early symptoms of granular kidney are the *hæmorrhagic* ones. A universal degeneration of arteries and capillaries is an essential part of the disease, and hæmorrhages may occur in any part where there are blood-vessels. I saw a boy of seventeen and a half in the Casualty Department here who came because his nose bled frequently. He was also subject to headaches, but did not mention that until the question was asked. The apex-beat was in the sixth space one and a half inches outside the nipple line, and there were no signs of valvular disease. The first sound was reduplicated. The radial arteries were thickened. The urine contained a trace of albumen. He was a printer by trade. Dr. West saw the case subsequently, and confirmed the diagnosis.

A middle-aged man came to the surgery because he had just been vomiting blood; he was a drinker, and the first things one thought of were cirrhosis of the liver and gastric ulcer. There were, however, no other signs of portal obstruction nor of gastric ulcer. On the other hand, there was a hypertrophied left ventricle, emphysema, hard arteries, and typical granular kidney urine; and I see no reason to doubt that the gastric hæmorrhage was due to arterio-capillary degeneration in the mucous membrane of the stomach.

I was called down to the surgery one night to see a patient who was spitting up blood. I found a man between twenty and twenty-five, very anæmic and thin, who had spat up a small quantity of bright frothy blood. He had never done so before. On examination I found, to my surprise, that there was not a single sign of phthisis, but that there was a very hypertrophied left ventricle, hard arteries, and typical granular kidney urine. He worked in tin. Unfortunately I have never seen the patient again, and the notes that I took were on the paper I gave him. Hæmoptysis is an extremely rare complication of granular kidney; Dr. West tells me he has never seen a case, nor has Osler; but as far as one can be certain of *any* diagnosis from a single examination of a patient I feel certain of this one.

Hæmorrhage may occur from the *kidney* in chronic interstitial nephritis, and is comparable to the other hæmorrhages. I have noticed in more than one case that puerperal women who have the cardio-vascular signs of granular kidney without any of the symptoms may pass smoky or pink urine for a day or two after delivery. It is

also an interesting fact that the symptoms of granular kidney may in a latent case be precipitated by *any* constitutional upset; thus a man may have the cardio-vascular signs for years, but all that time he may enjoy good health and pass normal urine, until one day he gets influenza, or has some great business worry, and from that time has headaches, giddiness, dyspepsia, polyuria, and so on. I have no doubt that the case I have mentioned of the woman of sixty who complained of polyuria was of this kind. She must have had granular kidney for years before she came to the hospital, but the symptoms were precipitated by mental excitement. And, conversely, in many of the cases in which the debility following a fever appears to be unduly prolonged, it will be found that the patient has the signs of granular kidney.

Hæmorrhages into the *retina and the brain* are of course extremely common in this disease. Hæmorrhage into the *skin* is rare, but it does occur, and Dr. West has published a case in which it was accompanied by another very rare complication, viz. detached retina.

As an example of the disease being easily recognisable before the patient has noticed any symptoms, the following is perhaps interesting. Last May I was left in charge, as *locum tenens*, of a lady who had cirrhosis hepatis, and various other alcoholic disorders. Considering the amount of organic disease that she had, her general condition was very good. After my first visit to her, however, she suddenly became moribund. Her brother pressed me to tell him what was the original cause of her troubles, and when I told him that the case was undoubtedly alcoholic he was very much shocked, partly because it was news to him that his sister tippled, and partly because it occurred to him that *he* might be going the same way. He suggested that I should overhaul *him*, and see that he was all right at present. When he came to see me after dinner he remarked with a cheerful smile that he did not seriously think there was anything the matter with him, for he felt in such perfectly good health, and, moreover, he insured himself a year ago, and was then accepted as a first class life. When I came to examine him I found his left ventricle hypertrophied, his lungs emphysematous, his liver down to his umbilicus; the radial artery was easily felt, although he was only thirty-six; the urine was 1010, with a trace of albumen. Although he considered himself in such perfect health, he admitted, on being asked, that he passed two or three liquid motions every day, and I noticed that when he walked a mile with me at a fairly brisk pace his breathing became very laboured, and on arriving at our destination he at once showed other signs of his condition.

When I say that granular kidney is an easy disease to diagnose, I do not of course mean that it is always easy to say in an advanced case whether we have to do with granular kidney or with some other serious disease. It may be a very difficult thing to say whether a dilated heart with anasarca is due to valvular or renal disease, and renal disease may closely simulate cerebral affections. I well remember a case in which I diagnosed mitral regurgitation with heart failure; one of my senior colleagues said it was a renal case primarily. Post mortem it was tubercular meningitis.

In another case a diagnosis was made of malignant disease in the region of the descending colon. Post mortem the lumps we had felt proved to be a cystic kidney about the size of two fists. The patient had died of uræmia. There is nothing like the post-mortem room for teaching us humility.

Now a word about the *treatment* of granular kidney. It is a favourite maxim of Sir Dyce Duckworth's that experienced physicians treat patients, not diseases; it is only homœopathists, he says, who treat diseases. There is no class of patient about which this is truer than the victims of granular kidney. No line of treatment will make a contracted kidney do all the work it was intended to do; no therapeutic measure will render an atheromatous tortuous artery thin and supple again. All we can do is to relieve the patient of some of the *results* of the organic disease, and induce him to abandon such modes of life as would encourage the progress of the morbid changes. By the time some serious complication has occurred, such as acute nephritis, uræmia, or cerebral hæmorrhage, the treatment of the case is pretty obvious, being simply that necessitated by the complication. But in the earlier cases—those that are so often overlooked—the choice of treatment requires careful judgment. Let me describe two patients suffering from this disease, each of whom is typical in his own way, and can be seen any morning in the surgery, but who present very different appearances and require equally different treatment. No. 1 is a big, beery, obese brute, who denies stoutly that he drinks to excess, but admits that he is a brewer's drayman. He is thirty-five to forty years of age, of florid countenance and fishy eyes. He complains of loss of appetite, and flatulence and discomfort after meals. He has frequent headaches. and his bowels are irregular; they may be either loose or constipated. His breath has the odour, not of the man who has just had a whisky and soda, but of the chronic soaker, which is very different. His tongue is coated with brown fur; his lungs are emphysematous, the area of cardiac dulness is diminished; the apex-beat is impalpable; the heart-sounds are muffled, but the aortic second sound is distinctly louder than the pulmonary. The pulse is of high tension, and the radial artery, though not extremely thick, is easily felt. He passed water just before he came in, but thinks perhaps he can make a little more. He at once supplies half a pint of pale urine, of sp. gr. 1010, which contains a minute trace of albumen.

No. 2 is a small, thin, cachectic-looking man, whose face is not only anæmic but sallow, his expression is serious and his spirits depressed, his skin generally is dry and inelastic, he is obviously wasted. He is forty years of age, but has already a well-marked arcus senilis. He has worked in lead. He says he drinks very little, and his appearance bears out the statement. He complains chiefly of lassitude and loss of appetite. His tongue is flabby and only slightly furred. His heart is found to be thumping away in the sixth space an inch outside the nipple line. The first sound is loud and reduplicated; the second sound is reduplicated and accentuated over the aortic cartilage. The radial artery is very thick and tortuous, but the pulse is of low tension. A low tension pulse with accentuated aortic second sound is quite a common combination in granular kidney.

These two men require very different treatment. No. 1 should be cut off his drink absolutely, and his butcher's meat should be limited or forbidden altogether. If he is constipated he should be purged freely, partly to eliminate the poison, partly to reduce the blood-pressure, and in any case his bowels should be kept open at least once a day. He should be given iodide of potassium, which will have some effect in lowering the blood-pressure and is said to improve the condition of atheromatous arteries He should also be given nitro-glycerine, the quantity of which must be regulated according to the effect it has on the blood-pressure.

No. 2 must be dealt with much more cautiously. He is already depressed mentally and debilitated physically. If one limits his diet to just those things which he cares least about, cuts him off his little drop of stimulant, purges him vigorously, and adds to his depression by giving him iodide of potassium, one will probably do him far more harm than good. I would rather give such a man a diet like the following. For *breakfast*, at 8 a.m., one egg with as many rashers of fat bacon as he cares for; *café au lait* to drink; this to be preceded when his appetite improves by a plate of porridge with cream or butter. *Lunch* at 11: a tumblerful of milk and an oatmeal biscuit. *Dinner* at 1.30: a chop with cauliflower or other fresh vegetables, one glass of Burgundy with as much soda-water as he cares for, bread and butter or milk pudding *ad lib.* *Afternoon tea* at the usual time. *Supper* at 8 p.m.: white fish, porridge with cream, bread and butter, milk pudding, one glass of Burgundy. After each of his three meals he should have a mixture containing tinct. ferri perchlor. ♏x, tinct. nucis vom. ♏x, out of hst. acidi nitro-hydrochlorici. His bowels should be regulated if necessary with gentle laxatives. A few weeks of treatment on these lines will probably be found to make a considerable improvement in the general health, and *then* the question of reducing the alcohol and meat may be reconsidered.

There is, of course, far more to say about the treatment of patients with granular kidney, but I mention these two cases merely as examples of the fact that it must be treated very differently in different cases according to the indications presented by individual patients. Not long since, a late student of St. George's told me that he had heard Dr. Dickinson say that it was a very fortunate thing that granular kidney was so seldom diagnosed, for in those cases in which it was recognised, the patient was almost invariably starved and his life shortened. I believe that this is no injustice to those practitioners whose knowledge of medicine is derived mainly from text-books.

Scarlet fever is generally an easy disease to recognise, but we occasionally let it slip through our fingers simply because we do not think of it. Thus the febrile stage may be so mild as to be called a cold, and neglected by the patient or his parents; then in the second or third week scarlatinal nephritis occurs, and one is called to see a child with general dropsy. Now acute nephritis without any chronic renal disease is almost always caused by a specific fever, generally scarlatina; therefore this disease should always be thought of when a child has acute nephritis.

W. G—, a boy of 6, was admitted August 28th, 1895, suffering from occasional drowsiness. The boy had the appearance of being in good health, and the symptoms complained of were quite indefinite, and not in any way suggestive of renal disease. He was only admitted because he was the son of one of the employés of the

hospital, and it was intended to send him out in a few days. In the course of the routine examination it was found that his urine contained one quarter albumen and casts, but there were no other physical signs anywhere. There was no œdema, and the skin was not desquamating anywhere. The following statements were now elicited from the mother. Two months ago the child went to stay with friends in the country, where he attended a school. Six weeks ago patient's neck began to swell on both sides about the angles of the jaw, and about the same time he had a "bilious attack." In other words, he had presumably sore throat and vomiting six weeks ago. Five weeks ago his school was closed on account of an epidemic of scarlet fever. The mother does not know that his face or feet have ever swelled, but thinks she remembers hearing something about his boots being too small for him while he was in the country. The boy developed no fresh symptoms while in the hospital, and was kept in bed until the albumen had entirely disappeared from the urine, five weeks after admission.

I was once expressing the opinion to a friend that acute nephritis in a previously healthy man was very rarely due to cold. My friend deprecated the opinion, saying that it certainly occurred sometimes, for his own father had had nephritis through sleeping on the floor. When I expressed surprise at this conduct on the part of a staid elderly gentlemen, my friend said, "Oh, we were all being turned out of our rooms at that time, because the house was being disinfected after a case of scarlet fever."

When a sick child is brought to one with a sore throat, and one finds well-marked false membrane on the fauces and soft palate, one may perhaps be excused for notifying it as diphtheria without further examination; but such a case ought to be examined for a *scarlet fever* rash, for exudation sometimes occurs in the throat of scarlet fever without any diphtheritic infection, and in that case is generally due to streptococci. I have seen one case of membranous laryngitis where there was no scarlet fever, diphtheria, or syphilis, in which the *Bacillus pyocyaneus* was demonstrated.

A few days after I had written this I was called to see a girl of seventeen who was complaining of a sore throat. The history was as follows:—She suffered frequently from sore throat. On Thursday she felt ill all day; on Friday morning she still felt ill, but she was working hard for the London Matriculation, which was to begin on Monday, and she went to school as usual; at school she found she could not work, and had to come home in the middle of the day. There had been no rigors or vomiting. I saw her at 5 p.m. She looked ill, and was anæmic; complexion rather muddy; the temperature was 101°. There was considerable glandular enlargement at the angles of the jaw, especially the left. The pulse was 124—that is, the frequency was considerably more than could be accounted for by the temperature, which by itself would have raised the pulse-rate to about 100 only. The tongue was furred; the fauces were slightly reddened, and the tonsils were not enlarged; behind the left tonsil, but *not on it*, was a small yellowish-white patch. The insidious onset, the rapid pulse, the patch in the throat, and the glandular enlargement, out of all proportion to the condition of the throat, led me to make a provisional diagnosis of diphtheria. At 10 p.m. there was a slight blush on the chest, and the face was distinctly more flushed than at my first visit. The patient had vomited copiously in the interval. The urine contained only a trace of albumen; and when the patch in the throat was rubbed with a sterilised swab for bacteriological purposes it came right off, leaving a surface which did not bleed. Next morning there was a typical scarlet fever rash, and Dr. Andrewes reported that no cultures had been obtained from the swab.

Again, the throat in scarlet fever may resemble a *follicular tonsillitis;* therefore it is necessary to exclude scarlet fever before a diagnosis of follicular tonsillitis is made in any case. The affection of the *joints* in scarlet fever may easily lead to the diagnosis of acute rheumatism, of which this case is an example.

E. W—, æt. 13, was first seen by me on July 29th, complaining of a rash on his legs. The rash was a discrete, slightly raised, purpuric eruption, which was scattered over the trunk and limbs but was most marked on the lower part of the legs; it was fading. The hands and feet were desquamating in large flakes. The temperature was normal. The pulse was 132. There was a trace of albumen in the urine. The boy was slightly anæmic, but there were no other physical signs whatever. The boy was not over-intelligent; but the following is the history I got from him and his mother. He has never had scarlet fever nor any other illness. He was quite well till three weeks ago (*i.e.* about July 8th), when he "came out red all over except his face;" there was no shivering, vomiting, or headache, but his throat was slightly sore. He was ill enough to be put to bed for about one day. The rash lasted two or three days. Four days after he was taken ill his ankles became swollen and painful; they remained so for about five days, and then his wrists swelled and became painful. He now went to a doctor, and was told that he had rheumatism and was given salicylate of soda. On July 25th he noticed that his hands were peeling, and on the 26th the purpuric rash appeared on his legs. The case as I saw it was fairly straightforward; there was a history of rash and sore throat, followed during the first week by painful joint swellings. At the time of the examination (the end of the third week) there was desquamation such as rarely occurs apart from scarlet fever, and there was still a little albuminuria. I had but little hesitation in notifying the case, and the medical superintendent of the hospital to which the boy was sent agreed with the diagnosis. But now let us look at the case from the point of view of the man who saw it when the joints had been painful for nine days. He saw an anæmic boy with rheumatic joints; there was no rash to be seen and no desquamation, and no history of an acute onset. Although he overlooked a case of scarlet fever, I think few of us would like to cast the first stone at him. And even now, if he were to rise up and say that the original rash was no doubt a rheumatic erythema, and that any erythema may cause peeling; that sore throat is almost as common in rheumatism as in scarlatina; that the late purpuric rash was peliosis rheumatica; that the rapid pulse was perhaps due to an active endocarditis; and that though the patient had lived for three weeks in overcrowded rooms with several other children none of them became infected, I think his case would appear fairly plausible.

Finally, it is well known that a *second attack* of scarlet fever often presents itself as a mere catarrhal sore throat without any other signs or symptoms whatever. Thus, then, acute nephritis in a child, any kind of acute sore throat or rheumatic joints, should make us think of scarlet fever as a possible cause. Dr. Andrewes published in the JOURNAL about a year ago an interesting paper on hospital sore throat, in which he showed that a sore throat of any degree from a mild catarrhal form to follicular tonsillitis or sloughing tonsils *might* prove on bacteriological examination to be *diphtheritic*. The practical outcome of these facts is that any acute sore throat should be regarded as possibly infectious. It is by no means impossible to mistake *measles* for diphtheria. Diphtheria is so much the commonest cause of laryngeal stridor in children that when one meets with this condition in a child who is ill and has no rash and no membrane on the fauces, one is very likely to call the case laryngeal diphtheria, and in at least nine cases out of ten the diagnosis will be right; but it must be borne in mind that among the early catarrhal symptoms of measles is laryngitis, and this may be severe enough to cause stridor before there are any other symptoms.

F. C—, æt. 13 months, was admitted for laryngeal obstruction. She was quite well till a week before, when she developed a cough; this continued till the day of admission, when the cough became croupy and the breathing noisy. The day before there was a little discharge from the nose and redness of the eyes. No history of exposure to infection of diphtheria. Two children in the house where patient lives had *measles* a fortnight ago. Patient has never had measles or any other illness. On admission the child was not very ill; the breathing was stridorous, but the laryngeal obstruction was not very great,—indeed tracheotomy never became necessary. There was no rash. Temp. 102·8°, resp. 40, pulse 160. General dry bronchitis existed, but no signs of pneumonia. There was nothing abnormal in the fauces, and little or no enlargement of glands at the angles of the jaw. There was a thick cloud of albumen in the urine. There was very slight injection of the conjunctivæ. Here, then, we had all the symptoms of laryngeal diphtheria, but an obvious possibility of measles. The diagnosis was discussed with some warmth, but I finally admitted the child to Radcliffe. Next morning, before I was up, I received two messages—one from Radcliffe to the effect that the child had developed a *measles* rash, and would I remove her as soon as possible; the other from the pathological laboratory, saying that the cultures of *diphtheria* bacilli had grown. When the child died, as these mixed cases almost always do, flakes of membrane were found in the larynx and trachea, and there was extensive double broncho-pneumonia.

I find that Osler says nothing about the diagnosis between measles and diphtheria in the early stage.

There are several conditions associated with *broncho-pneumonia in children* which are very easy to overlook, but which are very important. A child is brought to the surgery with a temperature of 104°, pulse 120, resp. 60 or 80, and signs of broncho-pneumonia are found in the chest. It looks a straightforward case enough, and one's first impulse is to send it as quickly as possible to the ward; and yet that innocent-looking child may cause an epidemic in the ward of *measles, whooping-cough*, or *diphtheria*, and make one more wary of broncho-pneumonias in the future. As a complication of *whooping-*

cough, broncho-pneumonia is particularly deceptive, for when a child with whooping-cough develops broncho-pneumonia, the whooping often ceases, to return again when the pneumonia has cleared up; but the child of course remains infectious all the time. There is one little symptom which is characteristic of whooping-cough, and may help in the diagnosis of these cases; a child with whooping-cough often coughs till he is sick, *even though he does not actually whoop*, and this does not often happen with other coughs. Before we are justified, then, in treating a broncho-pneumonia as non-infectious, we must exclude measles, diphtheria, and whooping-cough. It is well to bear in mind, also, that broncho-pneumonia may be the only obvious manifestation of an acute general *septicæmia* or pyæmia; these cases are often extremely difficult to recognise even when one thinks of the possibility, but the difference in prognosis is of course enormous. The following is an abstract of the post-mortem notes on a child aged eighteen months, who was in the hospital for eight days and was thought to be suffering from simple broncho-pneumonia. "Right lung covered with purulent pleurisy; much collapsed, with patches of broncho-pneumonia. Left apex solid with broncho-pneumonia. Acute purulent pericarditis. Both middle ears full of pus." This was obviously a case of septico-pyæmia, of which the broncho-pneumonia was merely one among many manifestations. The case also serves as an example of the ease with which *pericardial effusion* may be overlooked.

There is a class of case occurring more often in children than adults which is very embarrassing. I mean patients who have a *high temperature with no physical signs* to correspond with it. These cases are very trying unless one has some system of examining them and sticks to it; and there is no better plan than to count the pulse and respiration, and then examine the various physiological systems in order, as in Dr. West's scheme. Look all over the skin for rashes; examine the heart and lungs; examine all the long bones and joints for swellings and tenderness, and the ears for discharge or offensive odour. Next, under the neuro-muscular system, examine the limbs for paralyses and rigidities; look for disorders of the cranial nerves and retraction of the head; examine with the ophthalmoscope. Under the digestive system examine the abdomen for tenderness, rigidity, distension, and enlargement of spleen; and *last of all* look at the inside of the mouth and throat, because this generally makes the child cry, and no further examination is possible. There is for some reason a great tendency to omit the throat from the examination of these cases; and it is a very important omission, because the cause of the fever is often found there, although the child may have given no indications that its throat is sore. Even adults who have follicular tonsillitis sometimes come complaining not of sore throat, but of pains in their limbs. It is generally hopeless to try to get a sick child to *consent* to have its throat examined; the thing must be done by force or fraud, and whatever way is the quickest is the best. I think the best plan is for the physician to sit facing the nurse with his knees nearly touching hers, and for the child to lie on its back with its hips on the nurse's knees and its head firmly fixed between the physician's knees.

The examination just described is quickly made, and if nothing abnormal is found, one can say that there are no physical signs of any of the *ordinary* pyrexial diseases. The question is then, what is it likely to be? It may be one of the infectious fevers—chicken-pox, scarlet fever, smallpox, measles,—and unless there is good reason for excluding each of these, the case should be treated for the time being as infectious. If, however, these are all put out of court (for instance, by the duration of illness, together with the absence of rash), and the fever is of several days' duration, the four things to be borne specially in mind are typhoid, meningitis, pneumonia, and influenza. In distinguishing between these without definite physical signs, the following small points are useful:—A *pulse-rate* which is slow in proportion to the temperature (for instance, temp. 103°, pulse 90), suggests typhoid or meningitis; *irregularity* of the pulse in addition to slowness suggests meningitis rather than typhoid; a *respiration-rate* which is rapid in proportion to the pulse-rate (*e. g.* resp. 40, pulse 110) suggests pneumonia. But, speaking generally, such a case should be treated at first as a typhoid, that being the commonest cause of prolonged pyrexia without physical signs.

In the case of children it must be remembered that "great events from little causes spring;" very insignificant ailments may cause very high temperatures. I have had a case of a child of three and a half with a temperature of 105° without physical signs, which came down in two days under the influence of aperients, and no signs of anything but constipation ever appeared. This fact, that a child may get high fever due only to constipation, always seems to me to have an interesting bearing on the causation of pyrexia in the puerperal period. Many people tell us that such temperatures are practically always septic. I do not believe it. It is generally admitted that a woman's temperature rises more easily than a man's, and a child's more easily than a woman's, and a *puerperal* woman's more easily than that of a woman who is not lying-in. All lying-in women, practically without exception, are constipated; constipation in children may cause a temperature of 105°; why should not the occasional harmless temperature of 102° in the lying-in wards be due to constipation? The fact that such a temperature comes down at once when a purge is given does not seem to me to be *against* this theory, although our friends explain it by saying that the purge merely sweeps out ptomaines which have been absorbed from the genital canal. I think the burden of proof rests with them.

On the other hand, a child may die with a high temperature before any physical signs or even any gross pathological changes occur.

A. W—, æt. 1 year and 11 months, was admitted because she had a temperature of 104°. Patient was quite well until the evening before admission, when she had a fit. She was immediately brought to the hospital, and was found to lie with her eyes closed, paying no attention to her surroundings. From time to time there was a convulsive stretching of the arms and trunk, and a sudden shrill cry. There was no squint. The temperature was 102°. She was admitted to the surgery ward, where she had a slight fit which lasted a few seconds and was accompanied by squinting. She was sick a great deal in the night. There was no history of infection or blow on the head. The bowels were open four times in the night. She was so much better in the morning that the question of sending her out was considered. By 2 o'clock, however, the temperature had risen again to 104°, and she was admitted to Elizabeth. At 5 p.m. the pulse was 200, and the respiration 50. There were signs of general bronchitis. About midnight the child was very restless, the pulse uncountable, the respiration 76, and the temperature 104·2°. A hot mustard bath improved the general condition very considerably, but an hour later the temperature rose to 107·2° and the child died, having presented no physical signs of anything but slight general bronchitis. At the post-mortem nothing was found but a few patches of collapse in the lungs, due to the bronchitis. This may have been the onset of one of the infectious fevers, or it may have been influenza.

J. R—, æt. 4 months, was admitted for pyrexia and collapse without physical signs. He was quite well in the morning of the day of admission, but at 3 p.m. his mother noticed that he was drowsy, seemed ill, and was blue about the face. He "came out hot and went cold again." The history reveals absolutely nothing else of any interest about the case. When seen the temperature was 102·2°, respiration 52, heart-rate about 200, but it was too rapid to count, and the radial pulse could not be felt. There was a double external squint which came and went. There was one vaccination scar on the left arm. At midnight there were a few purpuric spots on the face about the size of a split pea. Similar spots came out all over the body before the child died at 2 a.m. Post mortem the spleen was slightly enlarged, but nothing else was found. Dr. Kanthack examined the spleen bacteriologically, but with negative result. This may have been malignant smallpox.

Considering what a very unmistakable disease *pneumonia* is in its typical form, it is wonderful how it tricks us occasionally; sometimes by presenting no physical signs, at other times by causing no constitutional symptoms. When a patient is very ill with some other febrile disease it is quite possible for him to develop pneumonia without any fresh symptoms, so that one only discovers it on a routine examination of the chest, and not always then.

A pneumonia may be straightforward in every way, except that its physical signs may be very late in appearing, and this is very puzzling for the first few days. A boy of nine was admitted to the Royal Free Hospital acutely ill with high fever. He was seen on the sixth day of his illness by a house physician, who found no physical signs, and referred the case to the out-patient department. The assistant physician at about 4 p.m. found no physical signs, and suggested typhoid fever. At midnight there was absolute dulness and loud bronchial breathing all over one base; and the crisis occurred next day.

Among the less common causes of pyrexia without physical signs, perhaps *acute miliary tuberculosis* and *infective endocarditis* are the most important, and they certainly escape diagnosis as often as most things. The latter should always be thought of when a subject of chronic heart disease gets prolonged pyrexia without obvious cause. Acute tuberculosis should be suspected in any case which is believed to be typhoid but in which the diagnosis is not perfectly clear. The following case is interesting, if only from the number of diagnoses that were made. I first thought the temperature was *emotional*; when it persisted with a slow pulse I thought it was due to constipa-

tion, which the patient undoubtedly had; finally I found some signs in the chest and diagnosed *chronic phthisis*. The case next came into the hands of an outside practitioner, who notified it as *typhoid;* at the fever hospital a diagnosis of *meningitis* was made. Post mortem it was *acute general tuberculosis*.

Mrs. C—, a primipara æt. 21, was delivered of a seven months' baby while on her way to the General Lying-in Hospital, Lambeth. She was with her husband when the accident occurred, and he carried her the rest of the way to the hospital. When she arrived the placenta was found to be entire, and the perinæum intact. The following morning the temperature was 103°, pulse 92, resp. 16, and apart from the temperature the patient seemed quite well. I thought the excitement of the previous evening was enough to account for the pyrexia. The temperature persisted, however, and I made a cursory examination of the apices of the lungs, and found nothing. As the pulse was slow and the lochia normal, and no vaginal examination had been made, I felt convinced the case was not septic. The patient suffered from chronic constipation, and every purge was followed by a large, hard, scybalous motion; the abdomen was slightly distended, but not tender, nor was there any local resistance. This state of things went on for a fortnight, the temperature ranging from 101° to 103°, but the patient being otherwise quite well. The bowels were open twenty times in thirteen days.

On the thirteenth day I examined the chest more thoroughly, and found signs of thickened pleura at the right base, but no signs of any active phthisis anywhere. She had never had any symptoms of phthisis. She was one of a family of five, of whom one had died of phthisis and the rest were healthy. I thought then that the temperature was due to tubercular disease of the lungs which was more active than the physical signs alone would lead one to suppose; and I accordingly discharged her from the lying-in hospital. In a few days she was so ill that a general practitioner in the neighbourhood was called in; he attended her till the thirtieth day, when he sent her to a fever hospital as typhoid fever. There she was found to have signs of meningitis, which taken with my previous opinion that the case was tubercular, made it easy to diagnose acute general tuberculosis. Although the diagnosis was not completed during life it was made before the body was opened. The meninges, lungs, pleuræ, peritoneum, liver, spleen, and kidneys were crammed with tubercles; and there was great thickening of the pleura at the right base, but no ulcerative phthisis.

I suppose pregnancy caused the general infection in a tuberculous subject, and the acute fever caused premature labour.

I will conclude with a case which is, I think, not an unfair example of the difficulties that may be presented by *ulcerative endocarditis*. A youth of eighteen was quite well till January 5th, when he played football; he did not know that he received any injury during the game, but his father said that he did not look well that evening. On January 6th he still looked unwell, but did not complain, and went out. About 9 p.m. he complained of pain in the left groin. On January 7th he went to his work, though still in pain, and stayed at it all day. On his return from work he looked pale, could not eat his supper, and went to bed still complaining of pain in his left groin. On January 8th he only succeeded in getting downstairs, and had to return to bed at once. He was admitted the same day to the hospital, when the temperature was found to be 104°, and the pain in the groin persisted. The abdomen, external abdominal rings, and rectum were perfectly normal, with this exception, that in the left inguinal region there was great tenderness on palpation, the pain and tenderness corresponding closely in position with the course of the spermatic cord. Movement of the left thigh caused pain in the left groin. On January 9th condition about the same, both generally and locally. On January 10th patient seemed more ill; tenderness in groin diminished; expression much more that of a patient with abdominal disease than it had been. Towards night he got into a state of low delirium, with a running pulse of 140; he had hiccough, and passed urine and fæces under him. On January 11th the Hippocratic expression of face became more marked; he cried out with the pain, and drew his legs up. Towards night he became quite comatose, the lungs became clogged, and he died. Post mortem there was infective endocarditis with pyæmic foci in the liver and kidneys, and a pyæmic embolus in the left middle cerebral artery. Nothing was found to account for the pain in the groin.

Such, then, are the monkey tricks of which infective endocarditis is capable. Small wonder that it is often overlooked!

Gentlemen, it only remains for me to thank you—and I do so most heartily—for the patience with which you have allowed me to talk about things which are, I fear, more interesting to myself than to anyone else. If I am told that I have said nothing new, that the cases I have quoted are wayside examples of facts which are perfectly familiar to every member of the Abernethian Society, I fully admit the justice of the criticism; but I would at the same time remind you that though many of the mistakes I have mentioned were merely my own, and therefore not surprising, *some* of them have been made by men of ability and experience, visiting physicians to hospitals, physicians to insurance companies, and so on; and this, I hope, is a sufficient excuse for my attempt to put a danger-board in front of them—

TO DOCTORS.
THIS CASE IS DANGEROUS.

A Case of Puerperal Eclampsia.

By G. E. DODSON, M.R.C.S., L.R.C.P.

THE notes of the following case, which occurred under my care as Extern Midwifery Assistant, are published by kind permission of Dr. Griffith.

The patient had had three previous full-term easy labours—all three children, girls, being alive and well. She had since had two miscarriages, both at fourth month, the last twelve months ago. There was no history of "fits." She had never before had a serious illness. Her feet did swell slightly during the later months of the three full-term pregnancies, but not so much as during the present one. For the last three years she has had to get up at night to pass water one or two times, whether pregnant or not; there were no further indications of pre-existing nephritis.

On August 9th, 1897, she was delivered at 3.12 a.m. of a male child, healthy, 7¾ lbs. in weight. The occiput presented in the second position; the labour was easy, and lasted eight hours. The placenta was expelled half an hour after the child, some membranes (chorion and amnion) being retained. Very little blood was lost. Slight œdema of feet and legs was noticed.

At 8.30 a.m. she had a "fit," and when seen fifteen minutes later was quite sensible, but very restless. Pulse 120, small volume, high tension. No premonitory symptoms had been noticed.

At 9.15 a.m. a second fit occurred, which was severe; she suddenly lost consciousness, and her eyes turned upwards and to the right, remaining so during the toxic stage of fit; both hands were thrown up above her head, and her face grew increasingly cyanosed. No conjunctival reflex was present. This lasted about a minute, and then she began to struggle violently, being still unconscious, and continued to do so for about five minutes, after which she became quieter and conscious, although still restless. There had been no aura or cry. She had no headache, and was not sick; her pupils were of natural size, and her breathing was slightly hurried. Pulse and temperature normal.

At 9.45 a.m. chloroform was administered, and the retained membrane removed by hand; a catheter was then passed, and a pint of urine drawn off. The urine, which was clear, became solid on boiling, and contained epithelial tube-casts. On recovery from anæsthesia she was quiet and sensible. She was given Pot. Brom. gr. xx, chloral gr. xx, by mouth.

During the day, from 10.30 a.m. to 3.45 p.m., she took nearly two pints of milk by mouth. She was not sick or giddy, but complained of severe headache, and sweated profusely.

At 1.5 p.m. a third fit occurred, of similar character to the one described, and the dose of bromide and chloral was repeated.

At 3.30 p.m. a fourth fit occurred; after each entire consciousness returned.

At 3.45 p.m. a fifth fit occurred, after which she did not regain consciousness, and struggled violently; but for restraint she would have thrown herself off the bed and injured herself. Her pupils were now pin-point, reflexes were absent, and her face was rather cyanosed.

At 4 p.m. chloroform was administered, which soon quieted her. Under anæsthesia the condition of the pupil did not alter, and her breathing was stertorous when she was not struggling.

At 4.45 p.m. a subcutaneous injection of gr. ¼ morphine acetate was given. Pulse 150, high tension; temp. 102·2°.

At 6.30 p.m. gr. ¼ of morphine was injected.

At 8.5 p.m. croton oil ♏ij was given on back of her tongue. This gave no result. Pulse 122, high tension; temp. 102·9°.

At 8.20 p.m. a catheter was passed, and half a pint of urine drawn off. Pulse 130.

At 8.30 p.m, the high pulse tension still continuing, Dr. Roberts advised bleeding, and a pint of blood was let from the right median basilic vein; this lessened the cyanosis, and lowered the pulse tension.

At 11.15 p.m. patient, still unconscious, was admitted to Martha Ward, under the care of Dr. Griffith. Until her admission, since 4 p.m. chloroform had been given intermittently about every quarter of an hour; if delayed for a longer interval she began to struggle violently. As the effect of the anæsthetic passed off, the slightest noise or jar in the room was sufficient to cause this. While quiet the breathing was stertorous, but each time, before struggling began, it grew more shallow and rapid, becoming less stertorous; a small quantity of chloroform sufficed each time, ʒxxiij being given in all. After admission to hospital no more chloroform was administered; her breathing grew less stertorous, no more fits occurred, and she struggled less violently, and at intervals only.

At 12 midnight she became purposive in movements.

August 10th—3 a.m., she became rather collapsed; ʒss brandy given, and her condition improved.

At 4.45 a.m. she passed urine under her.

At 5 a.m. conjunctival reflex returned.

At 7 a.m. pulse 120; temp. 103°.

By 11 a.m. consciousness had sufficiently returned for patient just to answer questions, but no more; she was very restless and irritable. Her breathing was laboured, but the breath-sounds were well heard at the bases of the lungs.

The albumen in the urine amounted to one quarter on settling.

At 3 p.m. patient took milk by the mouth, and ʒiv of brandy in the twenty-four hours.

Subsequent progress.—During August 11th she completely recovered consciousness. Her bowels were freely opened after medicine. Pulse and temperature gradually fell to normal next day, and the amount of albumen in the urine rapidly grew less; on the 17th only a cloud appeared after boiling. Some at least of the albumen present was paraglobulin, as was shown by its precipitation on saturation with magnesium sulphate. She was kept in hospital twenty-five days, as her temperature subsequently rose on three occasions to 101°, possibly due to slight suppuration in the lower end of the venesection wound. During her stay in hospital the quantity of urine was diminished in the second week; the absolute quantity of urea was subnormal throughout. The albumen varied in quantity, never entirely disappearing, and casts were frequently present. After the fifteenth day she got up daily, and she steadily progressed towards recovery, an attack of bronchitis being the only complication. She left hospital on September 3rd. When seen on September 22nd she considered herself well but for some bronchitis still present. On getting about her legs became slightly œdematous. The urine was not diminished in quantity now. She was advised to come up to hospital for treatment, as there were signs of effusion at the base of the left lung.

Notes.

THE APPOINTMENT of Dr. Kanthack to the Chair of Pathology at Cambridge can hardly be regarded as unexpected. Indeed, with such a candidate the result of the election on November 6th was a foregone conclusion. The electors were the Vice-Chancellor (Dr. Hill), Prof. Bradbury, Dr. Gaskell, Prof. Michael Foster, Dr. J. F. Payne, Prof. Clifford Allbutt, Sir James Paget, Dr. Donald MacAlister, and Dr. Latham; and their task must have been an easy one under the circumstances. No appointment could possibly be a more popular one, and we heartily congratulate Prof. Kanthack on achieving this distinction so early. Still more do we congratulate the University of Cambridge.

* * *

THE EAST WING of the Hospital is now re-opened, and we can judge of the many improvements introduced during the summer. The wards and landings have been re-floored with polished teak, and the walls painted a light red with a dado of a darker shade. The hypercritical æsthete may object that in the male wards (*i. e.* all except Paget) the red quilts on the beds afford neither a match nor a pleasing contrast. Hot-water pipes have been placed at the ends of the wards to reinforce the fires, and behind each stand of pipes is a ventilator which can be opened and shut after the manner of those in a railway compartment.

* * *

The new beds are of a modified "Lawson Tait" pattern; the metal-work being coated with white paint. It is an apparent drawback that the bed ends are both raised and immovable, which at first sight adds to the difficulty of applying extension apparatus. In Mr. Butlin's wards, however, we notice that this is overcome by a most ingenious appliance fitted to the foot of the bed. It is readily applied, and very stable when in position; altogether it is a great improvement on the old apparatus, and we congratulate the inventor on the mechanical skill displayed therein. The increased height of the bed is of course a great advantage both in nursing and clinical work.

* * *

The new lockers are elaborate and ingenious, and a great improvement on the old primitive style. The top part consists of two "pigeon-holes," one above the other, which may be closed at the side by a curtain; the roof is of glass, affording the means of ready inspection—a necessary routine after visiting days! This top piece supports a flap which is of the right height to be pulled over the bed, forming a convenient table for the patient. The foot of the locker contains quite a spacious cupboard. India-rubber pads protect the door of this cupboard and the table-flap from inflicting or receiving damage in their movements.

* * *

WE OWE AN APOLOGY to Sir Robert Craven, from whom we publish a letter in another column, for stating that he was not present at the Old Students' Dinner on October 1st. As he qualified in 1846 he was the "Father of the House" on that occasion.

* * *

IN ANSWER to numerous inquiries, we may state that Dr. Norman Moore finds himself unable to publish his Abernethian Address on "The Deaths of the Kings of England" earlier than Christmas.

* * *

THIS SESSION the courses in Chemistry have been considerably remodelled by Dr. Chattaway and Dr. Orton. It has been necessary to extend the course for the Conjoint Examination over the whole year instead of merely in the summer session as previously. This enables the subjects to be treated much more fully, so that students have an opportunity of doing more of the practical work for themselves than is possible in any similar course given elsewhere.

A SPECIAL COURSE of twenty lectures in Organic Chemistry will be given in future during the summer session to meet the requirements of the Conjoint Board and of the new syllabus for the Preliminary Scientific Examination at London University, which now requires volumetric analysis. Further, the class for the Intermediate M.B. Examination in Organic Chemistry is being altered to meet the new regulations. Dr. Chattaway advises candidates for the London examinations to obtain a copy of the new schedule, which is widely different from the present one in force.

* * *

WE HAVE RECEIVED a number of communications reflecting unfavorably on the note in our last issue with reference to the Army Medical Service and the prospects thereof. Naturally the subject permits of different views, and the note in question was not an *ex-cathedra* utterance, but merely an individual expression of opinion.

* * *

MR. D'ARCY POWER has sent us a copy of his address at the Veterinary College, in which he makes an appeal for the appointment of veterinary inspectors to work in conjunction with medical officers of health. Considering the influence that diseases of animals frequently have on man, this plea seems rational, and we may add, from a perusal of the pamphlet, practicable.

* * *

IF THE MODERN NOVELIST must deal with medical matters, why cannot he or she submit the proof to a professional opinion? we should be spared many startling passages. We have only just recovered from the pranks of a probationer with a morphia syringe in *The Christian*, and now we find the following passage in *The Beth Book* by Sarah Grand, whose unhappy handling of some medical topics in *The Heavenly Twins* may perhaps be still remembered.

* * *

"Mrs. Caldwell said very little. She was suffering from a great swelling at the back of her neck—an anthrax the doctor called it—and was not fit to be about at all .... The doctor came every day to dress the abscess on Mrs. Caldwell's neck, and every day he said that if it had not burst of itself he should have been obliged to make a deep incision in it in the form of a cross." After this amazing display of knowledge we do not shrivel up at the contemptuous indictment of the medical profession placed in the mouth of the heroine. And why add to the already portentous length of her tale by repeating the stale libels of the Anti-vivisection Society?

* * *

THE following notice has been forwarded to us by the secretary of the Guild of St. Barnabas for Medical Students.

The above Guild is now entering on its fourth year of existence. It was started in 1894 with the purpose of uniting together medical students, and assisting them to maintain a high standard of faith and practice in the exercise of their profession.

Members must be communicants of the Church of England; they undertake to follow a simple rule of life and to attend the monthly meetings so far as possible. The meetings are held on the first Wednesday in the month in the North-west Chapel, St. Paul's Cathedral, at 6.15 p.m. There is tea in the Chapter House at 5.45, followed by a short service, and an address by the Chaplain, Canon Newbolt.

Any student wishing to join or desiring further information on the subject is requested to communicate with the secretary, Mr. B. E. G. Bailey, 14, Woburn Square, W.C., or with the treasurer, Mr. R. Howard, Guy's Hospital, or to attend one of the meetings, when he would have an opportunity of judging for himself of the nature of the Guild.

* * *

WE ARE REQUESTED to state that the practices of the Choral Society take place on Friday evenings at 8.15. This Session the practices are being more largely attended than ever. Before long it is hoped that the Orchestral practices will be resumed on Friday afternoons.

* * *

IN CANON RAWNSLEY'S recently published *Ballads of Brave Deeds*, suitable reference is made to the bravery of Surgeon-Captain Whitchurch at the relief of Chitral. It is unnecessary to quote the stanzas, for every Bart.'s man knows the story.

* * *

ALL BART.'S MEN are proud of their museum, and justly so, as it undoubtedly contains the best collection of pathological specimens in London. In September we announced that the specimens added this year were on show, and we feel that special attention should be directed to them for two reasons; firstly, because they are nearly all preserved and mounted by a new method, and secondly, because there is no doubt that in the near future, specimens thus preserved will be shown at examinations in place of the present bleached spirit specimens. It will therefore be wise for men going up to accustom themselves to the appearance of those preserved by the new method.

* * *

About two years ago Dr. Kanthack, following a method described by Jores (*Centralblatt für allg. Path. u. pathol. Anat.*, 1896), began experimenting with formalin as a preserving fluid. By this method the colour of the blood is fixed by the formalin, and the specimen is then mounted in glycerine. Last year a few specimens thus prepared were put in the museum, and they proved so satisfactory that this year nearly 170 specimens similarly preserved have been added. These are the result of two years' experience and experiment, and there can be no doubt that in future nearly all our museum specimens will be preserved by this or allied methods. Its advantages are obvious; the colour is apparently permanently retained, and a properly prepared specimen shows exactly as when first removed from the body; not only are those which would formerly have been preserved in spirit vastly improved, but interesting and valuable specimens, which before the introduction of this method were lost from inability to preserve their colour, are now among the most useful and beautiful specimens in the museum.

The important question as to whether their colour is permanent is answered by the fact that the specimens added last year are as good as ever, and they have been exposed to the full action of light for nearly two years; and it should be remembered that, other things being equal, the worst formalin specimen is better than the best spirit specimen.

* * *

We understand that the new specimens are to be kept separate at present from the general collection, and will be placed in the glass cases on the ground floor.

* * *

We are conservative in many ways at Bart.'s—perhaps wisely so,—but we can claim at any rate to be first, so far as England is concerned, in up-to-date museum preparations. Many other museums are now trying the same process with considerable success, and in a few years no doubt all will do so. The days of spirit specimens are numbered, and in the future they will only be found in museums of antiquities. We give below a short list of a few of the more striking specimens.

No.	
380*b*	Exostosis.
1233*d*	Subpericardial Hæmorrhages.
1678*b*	Subpleural Growths.
1696*a*1	Broncho-pneumonia.
1702*a*	Œdema of Lung.
1728*f*	Sarcoma of Lung.
1885*e*	Omental Cysts.
1935*b*	Carcinoma of Stomach.
2203*b*	Nutmeg Liver.

No.	
2301*b*	Tubercle of Spleen.
2331*e*2	Renal Infarct.
2334*b*	Contracting White Kidney.
2341*h*	Tubercular Kidney.
2381*c*	Cystic Kidney.
2418*b*	Papilloma of Bladder.
2904*b*	Multilocular Ovarian Cyst.

Amalgamated Clubs.

ANNUAL GENERAL MEETING.

THE Annual General Meeting of the Amalgamated Clubs was held in the Medical Theatre on Friday, October 15th, Mr. Furnivall in the Chair.

The business was to elect the Secretaries for the next year. Mr. C. G. Watson was elected as Senior Secretary, *vice* Mr. R. P. Brown, who had resigned, and Mr. H. J Pickering as Junior.

CRICKET CLUB SEASON, 1897.

The past season of the above club has been one of the most successful for many years.

Sixteen matches were played, of which 8 were won, 4 drawn, and 4 lost. The one disappointing feature of the season was our performance in the Cup Ties. After easily disposing of London in the first round, an unaccountable collapse of the last five batsmen lost us the match against University College.

Turning to individual performances, Greaves for the third successive season heads the batting table with the splendid average of 45. Rose and Bond both scored consistently throughout the season, and made a great advance on their figures of the previous year. In bowling, Pank, Rose, and Sale bore the brunt of the work. Pank heads the averages with a record of 41 wickets at a cost of 10 runs each, and showed a welcome return to his form of 1895. Rose did several good performances, notably *v.* M.C.C., but was hardly so reliable as last year.

It is unsatisfactory to have to record that the state of the pitch at Winchmore Hill is far from good. We are glad, however, to be able to state that forty square yards will be relaid during the winter; so it is to be hoped that we shall be able to note a marked improvement next year.

BATTING AVERAGES.

	No. of innings.	Not out.	Total runs.	Highest score.	Average.
H. S. Greaves	14	2	548	152*	45·66
E. F. Rose	16	3	419	86*	32·23
H. Bond	17	3	352	83*	25·14
J. W. Nunn	13	1	208	44	17·33
J. C. Sale	13	1	198	69	16·5
H. E. Scoones	7	1	96	26	16
J. A. Willett	10	3	104	29	14·85
F. H. Maturin	12	1	148	39	13·45
H. Whitwell	16	3	162	36	12·47
E. Talbot	5	1	36	22	9
H. W. Pank	10	1	46	31	5·11

* signifies not out.

BOWLING AVERAGES.

	Overs.	Maidens.	Runs.	Wickets.	Average.
H. W. Pank	210	69	422	41	10 29
E. F. Rose	245·1	74	544	36	15·11
J. C. Sale	186	49	532	30	17·73
H. S. Greaves	65·1	16	199	11	18·09
J. A. Willett	107	25	236	13	18·15
H. Bond	10·3	1	40	2	20
H. Whitwell	71	14	218	10	21·8
E. Talbot	16	3	45	2	22·5

RUGBY UNION FOOTBALL CLUB.

ST. BART.'S *v.* CIVIL SERVICE.

Played at Richmond on October 9th. This, our first game, resulted in a defeat by 1 goal to *nil*. The game was of a scrambling nature. Want of condition was very apparent amongst the forwards, and the outsides did not combine well together. Towards the end of the game we improved somewhat, but never managed to make the most of our superior weight. Two freshmen, Walker and O'Neill, showed good form.

Team.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, C. A. S. Ridout (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett (captain), A. J. W. Wells, C. H. D. Robbs, H. C. Adams, J. M. Plews, M. B. Scott, A. O'Neill, J. A. West (forwards).

ST. BART.'S *v.* UPPER CLAPTON.

Played at Clapton on October 16th. A very close game, resulting in our favour by 1 goal 2 tries (11 points) to 3 tries (9 points). It took us some time to settle down, and Clapton started the scoring. Shortly afterwards Walker scored cleverly for us, and O'Neill only just missed a difficult kick. Just before half-time Bennett forced his way over the line. In the second half Upper Clapton again scored first. Bart.'s then pressed hard, and a very clever piece of passing amongst the outsides resulted in Plews scoring. This was converted by O'Neill. We still kept up the pressure, Mayo being conspicuous for several good runs. Just before the end Upper Clapton broke away and scored, but failed to convert.

Team.—T. M. Body (back); F. F. Shout, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West (forwards).

ST. BART.'S *v.* KENSINGTON.

Played on October 23rd at Wood Lane. This was a well-fought game, resulting in a very creditable victory for us by 2 tries (6 points) to *nil*.

In the first half the game was very even, each side in turn pressing. Shortly before half-time a good piece of passing between O'Neill, Fleming, and Robbs resulted in the latter gaining a try, which O'Neill just failed to convert. In the second half we pressed hard for most of the time, but only scored once more, when Bennett ended a forward rush with a try.

Our forwards played very well all through the game, and the outsides kicked and tackled well.

Team.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); A. W. Nuthall, H. Walker (halves); W. F. Bennett, J. K. S. Fleming, A. J. W. Wells, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill (forwards).

ST. BART.'S *v.* R.N.C. GREENWICH.

Played on Wednesday, October 27th, at Greenwich, and resulted in our favour by 2 goals (10 points) to *nil*.

At the beginning of the game we pressed strongly, and after some capital bouts of passing among the outsides, Mason received a good pass from Mayo, and scored a try, which he converted. Almost immediately afterwards Mayo crossed the line, but was held up. The home forwards played much better after this, and we were driven back to our "25," where the game remained for the greater part of the first half. Dix, at back, had plenty of work to do to clear his lines.

After half-time play was very even. The outsides several times gained ground, but nothing further was scored until the last minute of the game, when Mason intercepting a pass, eluded the back, and scored between the posts. This he converted easily. For the last twenty minutes we were without Adams, who damaged his knee.

Team.—C. Dix (back); S. Mason, T. A. Mayo, C. A. S. Ridout, J. M. Plews (three-quarters); H. Walker, A. Ll. Vaughan (halves); W. F. Bennett, C. H. D. Robbs, H. C. Adams, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, R. im Thurn.

ST. BART.'S 2ND XV *v.* CIVIL SERVICE 2ND XV.

October 9th. Played at Winchmore Hill, and resulted in a win for the visitors by 2 tries to 1 goal—6 points to 5 points.

ST. BART.'S 2ND XV *v.* ROSSLYN PARK 2ND XV.

October 16th. Our opponents scratched, and the fixture consequently fell through.

ASSOCIATION FOOTBALL CLUB.

The list of fixtures for the coming season is again a long one, including out matches at Eastbourne, Tunbridge Wells, Dover, Sittingbourne, Salisbury, and Hastings. At the last-named place the team will be again entertained after the match by the old Bart.'s men resident there.

The second eleven also have a good list of matches to be played. With regard to the team several places have to be filled up. A goal-keeper has to be discovered; and at back, though we shall miss R. P. Brown, who captained the team for the last two seasons, yet we are lucky to have so good a player as Orton to fill the gap. At half-back the loss of Pickering, who has played so great a part in the successes of the last few seasons, will be keenly felt. In the forward rank Woodbridge and Robinson have left us, but with Willett, Talbot, Stone, and Marrett remaining, all of whom played last year, we should have a good line of attack.

Up till now, though there are several promising players, no great talent has been discovered amongst the freshmen. If there are any new players who have not yet had a chance to play, they should at once ask the secretaries for a game; and though owing to the number of players at the Hospital it is impossible for some to get regular places in the first or second elevens, yet all those, both freshmen and old members, who have therefore been obliged to join outside clubs should always allow the Hospital first call on their services.

ST. BART.'S *v.* CHESHUNT.

In this match, the first of the season, played at Cheshunt on October 9th, the Hospital started well, and playing a good game in the first half-time, crossed over leading by 3 to 1; but in the second half, owing to want of condition, the pressure was not kept up, and, in spite of good back play by Whitaker and Orton, Cheshunt were able to score two more goals, and so to make the result a draw—three all.

Goals for Cheshunt—Barwell (2) and Christie; for St. Bart.'s—Stone, Watson, and Bostock. Considering this was the first match, the Hospital played well, as Cheshunt had a strong team, and two of their goals were very lucky. At back, Orton and Whitaker were safe, and Watson, in his new position at centre half, tackled well forward. Stone played well, and Murdoch made some good passes. The teams were—

Cheshunt.—W. Bain (goal); E. Warder, J. E. Jull (backs); W. J. Shepherd, M. Ellis, H. J. Hargreaves (half-backs); C. Virger, E. J. Christie, J. R Barwell, B. Horley, W. K. Shearing (forwards).

St. Bart.'s.—E. F. Rose (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, R. Murdoch, G. W. Stone, L. E. Hughes, H. N. Marrett (forwards).

On Wednesday, 13th, Ealing were unable to raise a team, so the match was scratched.

ST. BART.'S *v.* R.M.A.

Played at Woolwich on Saturday, 16th, and resulted in a win for the Hospital by 2 goals to 1. The Hospital were not at full strength, and though they had the best of the game throughout they were only able to win by one goal. Walker scored both the goals for the Hospital. Team:

St. Bart.'s.—E. F. Rose (goal); L. Orton, L. E. Whitaker (backs); R. Bigg, C. G. Watson, E. H. Scholefield (half-backs); R. Walker, C. O'Brien, R. Waterhouse, G. W. Stone, H. N. Marrett (forwards).

ST. BART.'S *v.* EASTBOURNE.

Played at Eastbourne on October 20th. Result, defeat by 2 goals to love. The Hospital had bad luck, for Whitaker missed his train and could take no part in the game. Watson, therefore, went back, and Bostock to centre half, and Wethered, who came down as linesman, to half on the left.

Eastbourne, with a full side, including Topham, Willis, and Stansborough, soon started pressing, and in the first half-time scored twice and in the second half still continued pressing, but were unable to add to their score. This was due to the good defence of Orton and Watson at back, and of Rose in goal, who saved some fine shots. The rest of the team did not seem to play together, and there was a lack of lasting power, though Wethered must be congratulated on his first appearance at half-back. The forwards had few opportunities to score, and the shots they sent in were always dealt with safely by Lawrence in goal. Team:

St. Bart.'s.—E. F. Rose (goal); L. Orton, C. G. Watson (backs); E. H. Scholefield, A. H. Bostock, E. Wethered (half-backs); T. H. Talbot, G. W. Stone, J. A. Willett, R. Murdoch, H. N. Marrett (forwards).

ST. BART.'S *v.* REIGATE PRIORY.

Played at Reigate on Saturday, October 23rd. Reigate won by 6 goals to *nil*.

The game was played in a strong wind, which upset the Bart.'s defence—and the forward line was not at full strength. Reigate scored four goals in the first half, and two in the second.

Their first two goals certainly appeared to be won off side, and the decision of the referee affected the play of the Hospital. The best team undoubtedly won, but under conditions more favourable to Bart.'s the defeat would not have been so severe. Teams:

Reigate.—M. S. Barker (goal); W. A. Windsor, C. F. Holdsworth (backs); H. Dungate, F. J. Nightingale, G. Goodwin (half-backs); H. S. Goodwin, C. S. Kirkpatrick, H. L. Rogers, F. P. Sladen, H. Budgen (forwards).

St. Bart.'s.—E. F. Rose (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, L. E. Hughes, R. Murdoch, H. N. Marrett (forwards).

ST. BART.'S HOSPITAL *v.* WEST HERTS.

Played at Watford, October 27th. The Hospital were beaten by 5 to 1. The score by no means represents the state of the game. Though West Herts scored goals in the first half, St. Bart.'s had the best of the game in the second.

The large score against them was due to the inability of the forwards to shoot. Had they been equal to West Herts in this part of the game, and taken their opportunities, the scores would have been about level. Willett and Talbot played exceedingly well on the right wing, but the rest of the forwards lacked combination. The halves worked well, and Orton and Whitaker were as usual good at back; while Butcher, who was making his first appearance in goal for the Hospital, saved some shots very well. Talbot scored for Bart.'s. Team:

St. Bart.'s.—H. Butcher (goal); L. Orton, L. E. Whitaker (backs); R. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, C. W. Stone, C. O'Brien, H. N. Marrett (forwards).

ST. BART.'S *v.* CROUCH END VAMPIRES.

Played at Wood Green, October 30th, and resulted in a win for the Hospital by 2 goals to 1.

The home team pressed at first, and scored a goal. Bart.'s then got together, and Stone scored with a long shot. In the second half Bart.'s still kept up the pressure, and Stone headed through a second goal from an excellent centre by Marrett.

Willett and Talbot were away from the team, Waterhouse and Walker playing well in their places.

On the whole the Hospital played better than before, there being more combination; but the forwards must shoot whenever they get a

chance, as at present the goal average will need a lot of scoring to bring it on the right side. Whitaker and Orton were very safe at back, and Butcher in goal did well. Teams:

St. Bart.'s.—H. Butcher (goal); L. Orton, L. E. Whitaker (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); R. Walker, R. Waterhouse, C. W. Stone, L. Hughes, H. N. Marrett (forwards).

Crouch End Vampires.—W. L. Hollick (goal); G. S. Francis, C. M. Smith (backs); S. V. Windett, A. Sainsbury, W. Calldecott (half-backs); H. A. Potts, F. S. Windett, E. W. Newby, J. B. Niemann, H. Flowers (forwards).

SECOND XI.

Below is a list of the results of the Association "Reserve" matches, not so discouraging as at first would appear, since all the men are strange to each other, and the team is steadily improving every match.

			For.		*Against.*
Sat.,	October	9th.—Beckenham II.....	2	...	4
,,	,,	16th.—Tonbridge	0	...	5
Tues.,	,,	19th.—Forest School.....	0	...	1
Sat.,	,,	23rd.—Barnes Incogniti ...	2	...	7
Wed.,	,,	27th.—Proprietary School	0	...	0
Sat.,	,,	30th.—Old Foresters II.....	1	...	3
Wed.,	November	3rd.—Berkhamsted School	5	...	4

Abernethian Society.

ON Thursday, October 21st, the Society's first Clinical Evening of this Session was held, Mr. Langdon Brown in the chair. The following gentlemen showed cases or specimens.

Mr. Hussey showed two cases of coloboma iridis, the chief interest of the cases lying in the fact that they occurred in twin brothers. The malformation was situated vertically downwards in the left eye in both cases. There was no family history of the defect.

Mr. Hussey also showed a stained film of blood containing malarial parasites.

Dr. Morrison showed a case of supernumerary fingers and thumbs. There was a strong family history in the children, but none in the previous generation. He also showed a specimen of placenta prævia with a velamentous insertion of the cord, which had been ruptured in turning the fœtus.

Mr. Horder exhibited a case of supposed Addison's disease in a child of seven. The condition had greatly improved under treatment with supra-renal extract and iron. He added that Dr. Gee regarded the case as probably anæmia with "vagabond's bronzing."

Mr. J. P. Maxwell showed microscopical specimens of rodent ulcer and epithelioma of the scrotum.

Mr. Thursfield showed for Mr. Briggs a young man with a pulsating orbital tumour, over which a distinct bruit could be heard. This had been noticed one week after a bicycle accident.

Mr. J. L. Maxwell showed a child with a congenital sacral tumour. This was regarded pathologically as an adenoma of the post-anal gut.

Mr. Emery showed a specimen of carcinoma of pylorus, the peculiarity of the case being that although the pedunculated growth almost entirely occluded the pyloric orifice, there were no symptoms of it during life. He also exhibited three microscopical specimens of Molluscum contagiosum, showing their formation. He pointed out how the so-called cancer parasites were almost identical with the molluscum bodies.

This ended the meeting, which was a most successful one, both cases and specimens being considered highly interesting by all present.

On Thursday, October 28th, Mr. Hussey in the chair, Mr. J. D. Rawlings read a paper on "Some Diseases often Overlooked." A communication full of practical clinical interest was expected, and that this expectation was not disappointed will be clear to all who peruse his paper, which is published *in extenso* in this issue of the JOURNAL. His audience was so conscience-stricken that some interval elapsed before the discussion began.

On Thursday, November 4th, Mr. Hussey in the Chair, Mr. T. P. Legg read a paper entitled "Appendicitis." This paper also we hope shortly to publish in these pages, as the careful work it embodied well merits attention, apart from the intrinsic importance of the subject both in its medical and surgical aspects.

EMPYEMATA OF THE NASAL SINUSES.

Abstract of a paper read before the Society on October 14th, by J. J. GRACE, M.B., B.S., F.R.C.S.

I MAKE no apology for the subject of my paper, for I think empyemata of the nasal sinuses are more common than is generally supposed. Most of those unaccountable abscesses, for instance, which occur in the orbit originate, I believe, in the nose.

In the first case of this kind with which I had to deal the patient had syphilis with the usual perforated palate, &c., and was complaining of severe headache. I treated her with potassium iodide, but did her no good. A fluctuating swelling appeared on her forehead, and looked very like an abscess. One day I examined her nose and removed some dead bone. An immediate outflow of most stinking pus followed. From this moment she got quite well and the lump disappeared. Subsequent experience has convinced me that this was a case of empyema of the frontal sinus, and the swelling an abscess in connection with it.

I would like before continuing to recall to your minds some of the anatomy of the middle meatus.

Under cover of the anterior portion of the middle turbinate bone will be found a groove called the hiatus semilunaris, which is formed by the projection, in front, of the uniform process of the ethmoid, and, behind, by the projection of the bulla ethmoidalis, which latter is formed by some of the anterior ethmoidal cells. The hiatus semilunaris is continued above to form the duct of the frontal sinus, and below has the opening into it of the antrum of Highmore. Above the bulla ethmoidalis is the opening of the anterior ethmoid cells.

The hiatus semilunaris is not always continued upwards to the frontal sinus, however, for that cavity often opens in front of the hiatus.

Into the superior meatus open the posterior ethmoid cells, and above the meatus on the posterior wall opens the sphenoidal cavity.

The causes of nasal sinus empyema are *rhinitis*, acute and chronic, the former affecting the sinus by spreading directly to it, the discharge subsequently decomposing; the latter acting, I think, in the same manner, though some authorities are of opinion that chronic rhinitis simply blocks the opening into the sinus; that a partial vacuum, and so increased exudation to fill it, is the result. Polypi are said to act in the same way.

It is certain that polypi or chronic rhinitis are present in all cases, but I think they are due rather to the irritation of the discharge. Syphilis is undoubtedly a cause.

In the case of the antrum two more causes may be recognised. The proximity of the roots of the teeth renders it not uncommon for inflammation to spread from them, generally from the second bicuspid or first molar.

Owing to the relative anatomical positions of the openings of the frontal and maxillary sinuses, the latter can probably be infected from the former.

The symptoms differ as the orifices of the sinuses are closed or open. When the orifices are closed the symptoms are due to pressure.

Pain is severe and neuralgic, often associated with tenderness over the part affected. The severe pain is accounted for by the near neighbourhood of branches of the fifth.

Later, we have bulging of the walls of the cavity and the pointing of abscesses.

When the orifices are not occluded, pain is still present, but shifty in character. The main symptom, however, is unilateral nasal discharge. Other causes of unilateral discharge, such as foreign body, syphilis, or new growth, are of course easily excluded. In the case of the antrum this discharge is intermittent, for the opening being nearer the roof than the floor of the cavity, the discharge can only get out when it is tilted. Another feature of discharge from sinus disease is that the patient notices the smell himself, while it is not obvious to those around.

An examination of the nose should now be made. A mass of polpyi or some chronic rhinitis may be seen. The latter is generally localised to the anterior part of the middle turbinated bone, or may affect the olfactory fissure. If nothing abnormal appears in front, examine the posterior nares.

Polypi or hypertrophic rhinitis will be found even in cases when the empyema is closed, for in every case there was a time when the orifice was not blocked. If polypi are present pull them out, and this may be followed by a gush of pus, immediately establishing a partial diagnosis. I will detail the method of completing this later on.

Let us suppose now that all polypi are removed and there is no hypertrophic rhinitis to deal with, but no pus has appeared. The

best thing to do is to make an experimental puncture into the antrum, for remember the patient's symptoms are grave. Before this, however, Heryng's method of transillumination may be employed, but it is uncertain owing to the fact that the antra are often unsymmetrical. Another precaution is to see if the antrum cannot be entered by the normal openings. For this purpose the probe is bent outwards and a little downwards, one centimetre from its end, and the point is introduced into the middle meatus. It can be felt to pass over the raised edge of the hiatus, and should then enter the opening. In general, however, the middle turbinated bone overhangs too much to allow of this procedure. A second attempt may be made to enter by the accessory opening when present.

The experimental puncture is made in the inferior meatus halfway along the inferior turbinated bone and just below it. This will exclude the antrum. Next, we must exclude the frontal cavity. The lip of the probe is bent upwards nearly to a right angle 2 centimetres from the end and passed up the hiatus semilunaris into the sinus. If the middle turbinated body is in the way its anterior part must be removed. When the opening of the sinus is in front of the hiatus the manipulation is easier.

To exclude the anterior ethmoidal cells, the probe is passed in just behind the bulla ethmoidalis, between it and the root of the turbinated body. The probe is bent outwards and upwards not more than 1 centimetre from its end.

To probe the sphenoidal cavity the probe must be 6 centimetres long, 4½ to 6 centimetres disappearing in the nose. It has a slight curve over its whole length. It is passed, with the concavity of the curve outwards, from the nasal spine of the maxilla upwards and backwards past the middle of the middle turbinated bone until arrested by the wall of the sphenoidal sinus. A few lateral or vertical movements of the point will then usually find the orifice.

I know no means of diagnosing disease of the posterior ethmoidal cells except by a process of exclusion.

It often happens that more than one sinus is diseased in the same patient. When the empyema is closed we can only judge of this complication by the persistence of symptoms when one abscess has been opened. The empyema is not generally closed, however, and by syringing out each cavity in turn and noting the reappearance of pus in the middle meatus we can complete the diagnosis.

Treatment consists in the general treatment of polypi and hypertrophic rhinitis, followed by the washing out and draining of the cavities. In the case of the antrum the best place to conduct this is through an opening in the canine fossa, as it can be easily got at, and the cavity can be packed through it if necessary. In the case of the other cavities the treatment must be conducted through the natural openings. In the case of the frontal sinus an additional opening can be made by trephining the frontal bone over the inner third of the supra-orbital ridge.

The Rahere Lodge, No. 2546.

AN Emergency Meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant on the evening of the 9th inst., Bro. W. J. Walsham, W.M., being in the chair.

Messrs. Cripps Lawrence, John Adams, M. L. Trechmann, and Ernest Westbrook were initiated into Freemasonry by Bro. Godson. Bro. Surgeon-Major J. G. Harwood, M.S., P.M., and Bro. Dr. H. A. Haviland, of Penang, the Straits Settlements, were elected joining members of the Lodge. Bros. McLean, Haines, Sargant, Matthews, and Shewell were raised to the third degree by the W.M.

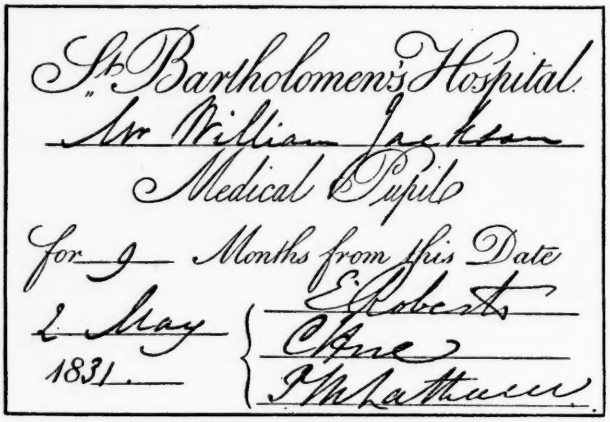
The Secretary gave notice of the Bi-centenary of the opening of St. Paul's Cathedral, which is to take place on 2nd December, 1897, at 3.30 p.m. Tickets for the opening will be reserved for those members of the Lodge who send in their names to the Secretary (10A, Chandos Street, W.) on or before 21st November. There is no charge for the tickets. The service will be conducted with masonic ceremony, and the brethren will attend in craft clothing and jewels.

Thirty-four brethren with their guests dined together after the work of the evening was ended. Bros. Burns, Robinson, Trechmann, and McCann gave a most excellent selection of music.

An old "Pupil's Certificate."

WE are indebted to Mr. Wallace Candler, of Stone, Staffordshire, for the loan of an old "Pupil's Certificate" such as were formerly issued at this hospital to medical students. The *fac-simile* may prove of interest to our readers.

[FACE.]



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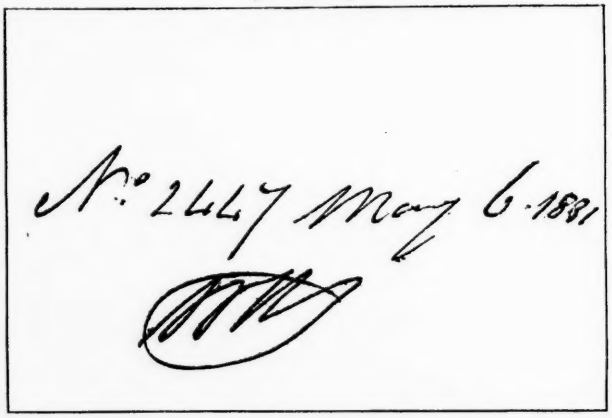

Volunteer Medical Staff Corps.

THE St. Bartholomew's Hospital Half-Company of the V.M.S.C. will hold their Second Annual Ball on Monday, January 24th, 1898, at the King's Hall, Holborn Restaurant.

The ball will be managed on almost the same lines as that held last January; each gentleman's ticket entitles the subscriber

to one invitation lady's ticket, which can be obtained by application to the Ladies Committee through the Secretaries.

As the ball is intended entirely for past and present Bart.'s men and their friends, it is hoped that it will have their hearty support; the attention of old Bart.'s men is especially called to this notice.

The gentleman's ticket inclusive of lady's invitation ticket can be got from any of the Committee or either of the Secretaries, price 15*s.*; owing to a large number of those present last January having expressed a wish that supper should be supplied, the Committee have decided to provide a supper as well as refreshments during the evening; in order to do this it has been found necessary to increase last year's subscription. Any further information will be supplied on application to any of the Committee, or to the Hon. Secretary, J. C. S Dunn, St. Bartholomew's Hospital, E.C.

The Month's Calendar.

NOVEMBER.

Tues. 16th.—Dr. Brunton's and Mr. Butlin's duty.
Wed. 17th.—Mr. Langton's Clinical Lecture, 2.45.
Thurs. 18th.—Abernethian Society at 8 p.m.: Dr. Morrison on "Albuminuria in Pregnancy."
Fri, 19th.—Dr. Church's and Sir T. Smith's duty.
Sat. 20th.—R.U.F.C. *v.* Marlborough Nomads, at Stamford Bridge. A.F.C. *v.* Civil Service A.F.C., at Chiswick Park.
Mon. 22nd.—Final Fellowship Examination. Bart.'s Cambridge Graduates' Dinner at Frascati's, 7 p.m., Dr. Hill in the Chair.
Tues. 23rd.—Dr. Gee's and Mr. Willett's duty.
Wed. 24th.—Mr. Langton's Clinical Lecture, 2.45. A.F.C. *v.* Casuals, at Winchmore Hill.
Thurs. 25th.—Abernethian Society, 8 p.m.: Mr. Drury on "Shortness of Breath."
Fri. 26th.—Sir Dyce Duckworth's and Mr. Langton's duty. Sir Dyce Duckworth's Clinical Lecture, 1 p.m.
Sat. 27th.—R.U.F.C. *v.* Croydon, at Croydon. A.F.C. *v.* Marlow, at Marlow.
Tues. 30th.—Dr. Hensley's and Mr. Marsh's duty.

DECEMBER.

Wed. 1st.—Mr. Langton's Clinical Lecture, 2.45.
Thurs. 2nd.—Abernethian Society, 8 p.m.: Discussion, Clinical and Pathological.
Fri. 3rd.—Dr. Brunton's and Mr. Butlin's duty. Dr. Hensley's Clinical Lecture, 1 p.m.
Sat. 4th.—R.U.F.C. *v.* Old Leysians, at Stamford Bridge. A.F.C. *v.* Tunbridge Wells, at Tunbridge Wells. Hockey Club *v.* Ealing 2nd XI, at Acton.
Tues. 7th.—Dr. Church's and Sir T. Smith's duty.
Wed. 8th.—Mr. Butlin's Clinical Lecture, 2.45. A.F.C. *v.* Sittingbourne, at Sittingbourne.
Thurs. 9th.—Abernethian Society at 8 p.m.: Mr. F. C. Wallis on "The Treatment of Spinal Caries."
Fri. 10th.—Dr. Gee's and Mr. Willett's duty. Dr. Brunton's Clinical Lecture, 1 p.m.
Sat. 11th.—R.U.F.C. *v.* Old Merchant Taylors, at Richmond. A.F.C. *v.* Newbury, at Newbury.
Tues. 14th.—Sir Dyce Duckworth's and Mr. Langton's duty. Meeting of the Rahere Lodge at Frascati's, 5 p.m.
Wed. 15th.—Mr. Butlin's Clinical Lecture, 2.45.

Reviews.

A HANDBOOK OF THERAPEUTICS, by Sydney Ringer, M.D., F.R.S., and Harrington Sainsbury, M.D., F.R.C.P.; 13th edition. (London, H. K. Lewis, 1897, 8vo, pp. 746; price 16*s.*).—A book which has reached its thirteenth edition can scarcely stand much in need of recommendation, and such as is required by this work will be freely bestowed by all who read it. Its interest is shown by the fact that we have read through the majority of its 700 pages, a feat of which the unaided conscience of a reviewer is barely capable; its value may be clearly seen on perusal of such a section as that on the preparations of arsenic. In these paragraphs we find blended the clinical experience which can dictate the remarks on aberrant types of asthma and hay fever, and the theoretical deductions from laboratory work which help to explain the action of this drug upon the skin. And these remarks will apply to all the contents of the book, from the introductory observations on the tongue and the pulse to the concluding Epicurean receipts for invalid cookery. Some of the latter help one to realise vividly the point of Charles Lamb's remarks on the pleasures of the sick bed! The revisions bring the work thoroughly up to date, for there are disquisitions on serum therapeutics and glandular extracts, and an account of the Nauheim-Schott treatment. We notice a short account of papaïn, the active principle of the fruit of the papaw tree, but no mention is made of the curious fact that apparently it is the only vegetable ferment which is of any use in the manufacture of cheese; which is not only interesting, but important, as the employment of rennin prevents this nutritious food being taken by large sections of the population of our Indian Empire. The drawback to papaïn in this connection is that it gives the cheese a bad colour. Nor do we find quoted the striking observations of Miss Mary Kingsley on its very active digestive properties. She tells us in her *Travels in West Africa* that it is commonly believed that "even if you just hang a tough fowl or a bit of goat in the tree among the leaves it gets tender in no time." She adds, "I certainly did once myself hang the leg of a goat no mortal man could have got tooth into on to a papaw tree with a bit of string for the night. In the morning it was clean gone, string and all." But perhaps such evidence is beneath the notice of a scientific text-book.

CLINICAL METHODS: a Guide to the Practical Study of Medicine, by Robert Hutchinson, M.D., M.R.C.P., and Harry Rainy, M.A., F.R.C.P.(Edin.), F.R.S.E. (London: Cassell and Co., Limited, 1897, price 9*s.*)

The chief fault which we find with this book is one which concerns the publishers rather than the authors, and it is one shared by all their series of *Clinical Manuals*. A book which aspires to be read should be capable of remaining open without having the binding almost smashed by forcible bending back of the covers. In spite of repeated performances of this operation, the book in front of us declines to allow us to read the page on which we have set our mind.

The authors appear to have done their work thoroughly and admirably. In the resources of clinical pathology we have a new method of examining our patients which must in time, with fuller experience, lead to almost as great advances as did the introduction of auscultation and percussion. They therefore justifiably devote considerable space and care to the description of these methods, and the accompanying plates will prove a great assistance to the student. Indeed, the copious diagrams scattered throughout the work are to be commended; motor points, parasites internal and external, surface markings, and many other subjects find appropriate illustration. The diagrams of the motor segmental functions of the cervical and lumbar enlargement strike us as quite new. Altogether this book forms a very useful work of reference.

THE LOCALISATION OF HEADACHES, by H. Bendelack Hewetson, F.L.S., Honorary Ophthalmic and Aural Surgeon, Leeds General Infirmary. (London: Simpkin, Marshall and Co, 1897.)

We must in the first place object to Mr. Hewetson's title-page.

Why an ophthalmic and aural surgeon should, when writing on a professional topic, simply label himself as a Fellow of the Linnean Society we cannot imagine. Mr. Hewetson apparently does not despise such baubles as medical diplomas and degrees, for to Professor Clifford Allbutt, to whom the book is dedicated, he allots these honours lavishly. And while grumbling we may also raise an objection to the unlovely head adorned with red patches on the cover of the book, and to the rather free use of leaded type in its pages. All this gives an unprofessional aspect to the work, and might lead to its sterling merits being overlooked, which would be unfair to the author, who has devoted much time and thought to its production.

Few ailments among those labelled as "trifling" are a source of more inconvenience to the patient and difficulty to the medical man than headache. In this book the very frequent connection between headache and an uncorrected visual disorder is insisted on; and further, the fact that general neuroses may occasionally have an ophthalmic origin is clearly pointed out. In many cases of the latter type the visual disorder may have never attracted the patient's attention, but is only found on examination by the medical attendant. The diagrams, many of them modified from Dr. Lauder Brunton's originals, lend emphasis to the text. From them we realise how very localised these headaches may be, even causing a modification in the style of dressing the hair with women to avoid pressure on the tender spots. The author suggests that this avoidance of pressure is also the origin of the short hair adopted by many literary ladies. Lest Mr. Hewetson should think we have only glanced at his title-page and diagrams, we may add that in the next edition of his interesting work we hope he will correct occasional barbarities of style such as exist at the bottom of pages 29 and 54, and the misprint "carodid" on page 133.

New Productions.

GLANDULEN, prepared by Dr. Hoffman [Thos. Christy & Co., 25, Lime Street, E.C.].—It is claimed that these tabloids, prepared from the bronchial glands, have a specific action in tuberculosis of the lungs. Amid the glut of extracts now on the market, it is refreshing to find one that offers a theoretical *raison d'être*. Ignoring the fact that the original success with thyroid extract was based on a careful observation of the facts of "internal secretion," manufacturing chemists provide us with extracts of every gland, and nearly every organ of the body. According to them, therapeutics have now become an exceedingly simple matter; a gland or organ is diseased—give an extract of it by the mouth; as to its mode of action, trust to the chapter of accidents. This is abhorrent to anyone whose methods aspire to be something rather better than these rules of thumb. It is the degradation of a system which offered a scheme of rational therapeutics. That a substance having active bactericidal properties may be extracted from lymphatic glands was shown some years ago; we believe this was first considered to be identical with the substance obtained by Halliburton from the lymphatic glands, and called by him Cell-globulin β. Much of this work has now only a historic interest, but the fact that a bactericidal body can be thus isolated still holds. It is quite possible, therefore, that an extract of bronchial glands should contain it abundantly, but we would suggest to the manufacturers that they should undertake and publish experiments to prove (1) that their extract has this action; (2) that this action is not destroyed by the gastric juice to which it must be submitted. Pending the publication of such experiments we may state that these tabloids are palatable, and from personal experience quite innocuous.

Appointments.

CHATER, J. S., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Surrey County Hospital, Guildford.

* * *

DYSON, M. G., M.R.C.S., L.R.C.P., appointed Second Assistant Resident Medical Officer to the Islington Workhouse and Infirmary.

* * *

HARRISON, L. K., M.R.C.S, L.R.C.P., B.A.(Cantab.) appointed Assistant House Surgeon to the General Hospital, Nottingham.

* * *

HOLMES, H., M.B., B.C.(Cantab.) appointed Junior House Surgeon to the Wigan Infirmary.

MANNING H. C., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Kent and Canterbury Hospital.

* * *

ROBINSON, C. A., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Hospital, Portsmouth.

* * *

THOMPSON, H. E., M.B.(Lond.), M.R.C.S, L.R.C.P., appointed House Surgeon to the Eye Hospital, Birmingham.

* * *

WHINCUP, F., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Salop Infirmary.

* * *

WOOD, J. H., M.B., B.S.(Durham), M.R.C.S., L.R.C.P., appointed House Surgeon to the Stockton and Thornaby Hospital.

Examinations.

D.P.H.CAMBRIDGE.—The following have passed both parts of this examination:—G. H. Cock, R. A. Farrar, S. Gillies, C. H. Graham, C. F. Lillie.

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FIRST CONJOINT.—*Chemistry and Physics*:—H. H. Butcher, C. Dix, L. C. Ferguson, H. P. Margetts, W. G. Paget, R. C. Wilmot.

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FIRST CONJOINT.—*Practical Pharmacy*:—H. E. G. Boyle, A. Butler, F. W. Cheese, A. G. Higgins, H. G. Pinker, W. H. Randolph, R. Thompson, F. J. Wood.

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SECOND CONJOINT.—R. Bigg, R. C. Bowden, H. A. Colwell, W. E. L. Davies, C. Fisher, E. V. Lindsey, H. E. D. Lloyd, H. W. Marrett, D. S. Sandiland, G. W. Stone, L. E. Whitaker, T. Young, J. E. Griffith, J. Valérie. Under old regulations A. Farrington has passed in Physiology.

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FINAL SOCIETY OF APOTHECARIES.—F. E. Fielden has passed in Medicine and Forensic Medicine. *Physiology*.—N. C. Beaumont, *Biology*.—H. M. Huggins. *Materia Medica and Pharmacy*.—H. F. Stilwell, R. Storrs.

Correspondence.

To the Editor of St. Bartholomew's Hospital Journal.

SIR,—I notice in your report of the Old Students' Dinner you state that Sir James Paget and Sir Robert Craven, of Hull, were unable to be present. This is incorrect so far as I am concerned. I was present, and Sir Thomas Smith in his speech stated that I was the oldest student present at the Dinner. I qualified in 1846.

Yours very truly,
ROBT. M. CRAVEN.

14, Albion Street, Hull;
October 31st, 1897.

Marriages.

CROSS—COURTNEY.—On the 5th October, at St. Peter's Church, Kirkley, South Lowestoft, by the Rev. Charles Tregenna, M.A., Rector, Henry Wingfield, eldest son of William Henry Cross, of St. Bartholomew's Hospital, London, to Rosa Millicent, younger daughter of Charles W. Courtney, of South Lowestoft.

COULBY—ROFE.—On the 19th August, at All Saints' Church, Bayswater, W., by the Rev. Charles Yeld, Vicar of Grassendale, Liverpool, and the Rev. C. H. Gern, Rector of Torpenhow, near Carlisle, uncle of the bride, George Arthur Coulby, B.A., M.B., B.C.(Cantab.), of Woodborough Road, Nottingham, to Laura Louisa, only daughter of Henry Rofe, of 8, Powis Square, W., late of Cavendish Lodge, Sherwood, Nottingham.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette, The Guyoscope, St. Thomas's Hospital Gazette, The Nursing Record, The Student.*